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ABSTRACT

This paper reviews research conducted over the past 25 years on the therapist's use of self-disclosure and the therapeutic relationship. Various definitions of self-disclosure are reviewed, the content of therapist disclosures is considered, and the choice to disclose is examined. Methods of measuring self-disclosure are discussed and research on therapist self-disclosure is reviewed. Findings from actual and analogous therapy situations are discussed which demonstrate consistent positive client responses to therapist self-disclosure. In contrast, surveys of therapists are reviewed which show a large variance in therapists' positions on the topic of self-disclosure. These findings are discussed within the context of the therapeutic process. Three components of the therapeutic relationship are identified: the therapeutic alliance, the transference relationship, and the real relationship. It is suggested that the difference between clients' and therapists' opinions on the value and appropriateness of therapist self-disclosure can be explained partially in terms of the therapists' greater understanding of the transference phenomenon and their deeper recognition of the tension between the needs to be be both neutral and real with clients. It is concluded that the varying degrees of emphasis that therapists place on the transference relationship parallel the disagreements among therapists of differing orientations over their beliefs about the place of therapist self-disclosure in psychotherapy, such that the more the transference relationship is emphasized, the less self-disclosure is valued. (41 references) (NB)

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THERAPIST SELF-DISCLOSURE AND THE THERAPEUTIC RELATIONSHIP

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Scott Thomas Winget

May 1991

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THERAPEUTIC RELATIONSHIP

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ABSTRACT

THERAPIST SELF-DISCLOSURE AND THE
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Scott T. Winget

Research on therapist's self-disclosure over the past 25 years is reviewed. In actual and analogous therapy situations, consistent positive client responses to therapist self-disclosure are demonstrated. In contrast, surveys of therapists are reviewed which show a large variance in therapists' positions on this topic. These findings are discussed within the context of the therapeutic process. Three components of the therapeutic relationship are identified: the therapeutic alliance, the transference relationship, and the real relationship. These are used to conceptualize therapist self-disclosure as paralleling the tension between the genuine and realistic functions of a therapist.

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Therapist Self-Disclosure and the Therapeutic Relationship

Introduction

The literature on non-specific self-disclosure has been summarized up through the mid 1970s (Chaikin & Derlega, 1974; Chelune, 1975; Cozby, 1973). In addition, Weiner (1983), has authored a book on therapists' use of self in psychotherapy. The early research on therapist self-disclosure examined a variety of similar concepts: authenticity (Bugental, 1965), congruence (Rogers, 1957), genuineness (Truax & Carkhuff, 1967), openness (Barrett-Lennard, 1962), and transparency (Jourard, 1964). The present paper examines the research on therapist self-disclosure over the past 25 years. This body of research consistently reveals positive client response to therapist self-disclosure. In contrast, surveys of therapists are reviewed which show a wide range of therapist's positions on this topic. These findings are discussed in terms of the psychotherapeutic relationship. Included in this discussion is an examination of the impact of therapist self-disclosure on the "therapeutic alliance," the "transference relationship," and the "real relationship." The debate over the use of therapist's self-disclosure is conceptualized as a tension which exists between the genuine and realistic functions of a therapist, and as such, one that all therapist's must struggle with in their work.

Defining Self-Disclosure

Cozby (1973) has suggested that there are three primary dimensions to consider when discussing the parameters of self-disclosure. First, self-disclosure can be described in terms of its breadth. This relates to the scope and amount of material disclosed. A second dimension of self-disclosure is that of depth. Not only can the quantity of material disclosed vary, but also its level in terms of degree of intimacy. Self-disclosure in this sense can be "superficial" or "close to home." For example, therapists' disclosures to their clients can range from simple facts, for example, where they are going on vacation, to intimate material such as the death of a spouse. Finally, self-disclosure always occurs within a certain time continuum, so that duration and timing are dimensions along which it can vary. Self-disclosure happens at certain times during a psychotherapy relationship and for specified time spans.

Others have suggested that there are additional dimensions to self-disclosure. Chelune (1975) argued that the rate of disclosure, and the degree of affect present during the conveyance of personal material are also important parameters. Most recently, Anderson and Anderson (1985) have suggested that self-disclosure can best be classified according to the similarity of disclosed material to the experience of the disclosee/patient, the positive or negative valence of the material disclosed and, as with previous systems of classification, degree of intimacy. These dimensions/parameters to self-disclosure are summarized in Table 1.

The Content of Disclosure

In his work on therapist self-disclosure, Weiner (1983) provided a description of the varying material therapists can choose to disclose about themselves. A partial list of these types of self-disclosure includes feelings, attitudes and opinions, the formulations and interpretations one arrives at, associations, the mental images and fantasies that spring to mind during a therapy situation, past experiences and personal data about oneself, and even physical contact with a patient. These types of disclosures are not limited to the therapy relationship. Rather, this list relates to those things people choose or choose not to share in all of their relationships.

Table 1

Dimensions of Self-Disclosure

	Investigators		
Dimensions	Cozby (1973)	Chelune (1975)	Anderson and Anderson (1985)
Breadth	X		
Depth of Intimacy	X		X
Duration	X		
Rate		X	
Affective Quality		X	
Similarity of Experience to That of Disclosee			X
Valence of Material Disclosed			X

The Choice to Disclose

In his review of the self-disclosure literature, Cozby (1973) looked at several areas that have been thought to influence one's disposition to disclose or not disclose personal information. In this regard Cozby examined both the personality and interpersonal factors which might correlate with self-disclosure. Perhaps surprisingly, the research he reviewed revealed few personality correlations with self-disclosure, and those that did exist were quite weak. He concluded that at best there might exist a relationship between sociability and extraversion and tendency to self-disclose. He remarked, however, that even the research regarding the effect of these traits on self-disclosure has generated contradictory findings.

Cozby (1973) expressed much more confidence that interpersonal factors correlate with self-disclosing behavior. He identified several of these factors, which he argued research had shown to correlate with degree of self-disclosure. The first was social exchange dynamics, or simply the rewards and costs over time associated with investing oneself in another person. A second interpersonal factor he identified as correlating with self-disclosure was the notion of reciprocity of communication. In this respect, Cozby cited studies which showed a high correlation of degree of self-disclosure between colleagues, family members, peers and even strangers. Cozby argued that the degree of liking and affinity toward another person was a third interpersonal factor which research has shown to correlate with self-disclosing behavior. Here the relationship was said to be curvelinear, in which a moderate degree of affinity often

corresponded to the greatest degree of self-disclosure. The need for social approval was the fourth interpersonal factor that Cozby argued was significantly correlated with level of self-disclosure This was said to be particularly true in terms of continuation of self-disclosure. The degree of approval a disclosee expresses toward material initially shared by a discloser was said to greatly affect that person's decision to disclose or not disclose additional material. The final interpersonal factor shown to correlate with self-disclosing behavior was degree of dependence for on another person. In relationships where individuals were roughly equal in their level of interdependency, the greatest amount of self-disclosure occurred.

Weiner (1983) pointed out that much of what is disclosed in interpersonal relationships is rather automatic and takes place without one's specific attention to it. He suggests that even if we should come to understand better the nature of conscious self-disclosure, much of what influences this behavior may be generated in the unconscious. This notion will be discussed again later in this paper.

The question as to the relationship between self-disclosure and mental health has been addressed by Jourard (1959), who argued that a curvelinear relationship exists between these two variables. In effect, Jourard argued that mentally healthy people should have the ability to disclose as well as to control the extent and timing of their self-disclosures. This argument has an intuitive appeal.

Measuring Self-Disclosure

The original and traditionally most used questionnaire for measuring self-disclosure has been Jourard's pioneering Self-Disclosure Questionnaire (JSDQ) (Jourard & Lasakow, 1958). Although this instrument has been criticized for its lack of predictive validity (Burhenne & Mirels, 1970), and despite numerous attempts at devising other measures (West & Zingle, 1969; Vondracek & Vondracek, 1971; Rickers-Ovsiankina, 1956; Polansky & Brown 1967; Taylor & Altman, 1966), the JSDQ continues to be a widely used descriptive measure in general research on self-disclosure. The JSDQ assesses six areas of self-disclosure: (a) attitudes and opinions, (b) tastes and interests, (c) work or studies, (d) money, (e) personality, and (f) body related material. As such it is a fairly comprehensive descriptive measure of the content of self-disclosure.

Cozby (1973) argued that much of the research he surveyed was difficult to interpret due to the lack of a sensitive measure of willingness to disclose. The lack of a predictively valid measure is complicated by the absence of a comprehensive measure by which to assess the breadth, depth and content of self-disclosure. Thus, a severe limitation in this area of research continues to be the need for better objective measures for adequately describing and predicting self-disclosure.

Research on Therapist Self-Disclosure

A trend can be seen in the progression of research on therapist's self-disclosure. Early studies were large and often times archival in

nature. They often involved reviewing large numbers of transcripts of old therapy sessions. Thus, they were more likely to focus on naturally occurring self-disclosure, both of a spontaneous and planned nature. The strength of these studies was that they were not laboratory based and therefore did not face questions of limited generalizability. To the extent that they were internally valid, their external validity was not in question. In addition, the treatment outcome of patients in these studies was often known, making it possible to address the question of the influence of therapist's self-disclosure on therapeutic success.

Criticism, however, has been focused on the internal validity of these studies. Their lack of well operationalized definitions for self-disclosure, and their poor control over confounding variables has led researchers to devise studies which provide for more experimenter control. As a result, the recent research has been largely analogous in nature. As will be seen, this recent research has turned up consistent findings as to clients' opinions of self-disclosing therapists. The generalizability of these research findings will depend on whether they extend to client's responses in actual therapeutic settings.

Early Research

The issue of the value of a self-disclosing, open stance versus planned and content-specific disclosures was addressed in the early research. Whitehorn and Betz (1954) found that schizophrenic patients responded more positively to being approached actively and personally than they did to passive permissiveness or interpretation.

It is difficult to substantiate the conclusion of Whitehorn and Betz that the content of disclosure is more important than an open stance by the therapist, given the lack of precision of their research. Nevertheless, this early work addressed the important issue of defining the parameters of what is meant by therapist self-disclosure. Recent research has attempted to define self-disclosure largely as a technique independent of the overall attitude of the therapist, thus leaving this critical question unanswered.

Truax and Carkhuff (1965) conducted some of the classic research on the effect of therapist transparency or congruence on patients. In their sampling of a large number of actual therapeutic sessions of an inpatient population they reported observing that increased therapist self-disclosure/transparency led to increased patient self-exploration, and finally to increased clinical improvement. This influence of therapists' self-disclosure on clients' active participation in treatment was also seen by Jourard and Jaffe (1970) who found a positive correlation between the amount of therapist self-disclosure and the amount of personal information a client shared.

In this early research the concepts of transparency, congruency, genuineness and self-disclosure were very loosely defined, making these findings difficult to generalize. For instance, the degree of transparency of therapists' communications was defined by Truax and Carkhuff (1965) partially in terms of the consistency of their expressions and partially in terms of the content of their verbalizations. One can easily see that definitions based on consistency and those based on genuineness are not equivalent.

Nevertheless, in contrast to the weaknesses of more recent research, the Truax and Carkhuff studies were large, actual therapy situations, and addressed outcome issues.

Doster, Matloff, and Samelson (1977) indirectly addressed the issue of therapist's self-disclosure in their research on subjects' reactions to instrumental versus expressive therapists. In two separate studies the investigators asked college students to rate tapes of simulated therapy situations. In these studies "therapists" adopted either an instrumental or expressive role. By definition the expressive role involved more self-disclosure. The authors found mixed preferences for the two types of roles amongst the subjects. When variability in the subjects was examined, however, they found that subjects with a perceived self-helplessness preferred the instrumental role, while those subjects displaying more confidence preferred the expressive role.

This early study of Doster and his associates did not adequately control for the variability between the instrumental and expressive conditions. Nevertheless, the study emphasized the importance of further research into the reactions of patients to their therapist's self-disclosures. In addition, the analogous nature of these experiments set a design precedent by which much of the more recent research is still modeled.

To summarize, the early research on therapist self-disclosure suggests that a relationship exists between a therapist's use of self-disclosure and client response and outcome in psychotherapy. The strengths of these early studies was in their large sample size and the

fact that they examined actual therapy situations in which treatment outcome was often known. In addition, early researchers acknowledged the need to distinguish between self-disclosure as an intervention and as a general stance taken by a therapist. These early studies were limited, however, by poorly operationalized definitions of self-disclosure, and a general lack of experimenter control. Thus, the question as to the specific nature of the relationship between therapist self-disclosure and client response remained unanswered.

Recent Research

As mentioned, the analogous experimental design of Doster and Matloff (1977) became the model for most of the modern research on therapist's self-disclosure. In addition, possibly in order to further experimental design simplicity, the recent research has focused on client perceptions of therapists who self-disclose, rather than on treatment outcome.

Fox, Strum, and Walters (1984) sought to look at patients' reactions to specific disclosures of therapists. In this experiment, the content of disclosure was therapists' experience in their own therapy. As with most other studies in this area, college students substituted for patients, and simulated transcripts replaced actual contact with a therapist. One hundred and seventy-five male and female subjects read a case history of a "therapist," which included information about the therapist's own therapy experience. There were three conditions for this variable: (a) no reference to therapy experience, (b) therapy obtained as part of a didactic training experience, and (c) therapy obtained because of personal difficulties.

In this between groups design experiment, the subjects read one of two "transcripts" which were identical except for the therapist's response to an inquiry by the patient as to whether the therapist had had any personal therapy. The therapist either disclosed this information or made an interpretive response that did not disclose the information.

All subjects were then asked to rate the "therapist" on three types of measures: eight bipolar adjectives, seven Likert scale questions pertaining to competence and attractiveness, and the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962). The 64, Likert-style questions on this measure were answered in order to rate the therapists in terms of the degree of empathy, regard, congruence and unconditionality they offered. In terms of the bipolar adjectives, the "disclosing therapist" was rated by subjects as more intelligent, likable, cooperative, easygoing, mature, responsible, reasonable, flexible, courteous, unselfish, as well as warmer, more sincere, more stable, stronger and better adjusted than the "non-disclosing therapist." In comparing the history variable of the "disclosing therapists," the "therapist" who had obtained therapy for didactic training was rated as more calm and stable than the "therapist" who had done so because of personal difficulties.

On the Likert scale questions, the disclosing "therapist" was rated as more capable of understanding, more competent, having more personal resources, having a more attractive personality, better able to understand patients' needs, and better able to get along with patients. Subjects also expressed greater willingness to see a

therapist similar to the disclosing "therapist." Finally, ratings on the Barrett-Lennard Relationship Inventory were likewise significantly more positive for the disclosing "therapist" than for the non-disclosing "therapist."

The clear preference for the disclosing "therapist" in this experiment suggests that a study of how actual clients respond to therapist self-disclosure is in order. Should similar findings result, the next question might be whether this preference would correspond to improved therapy outcome.

Loeb and Curtis (1984) explored subjects rating of "therapists" who varied in terms of "levels" of self-disclosure. These levels differed in their degree of self-reference of the therapist statements. In this between groups design experiment, 87 college students read one of three transcripts of a simulated therapy session, all of which were identical except for a systematic variation in the therapist's use of pronouns. In the personal self-reference condition, the "I" pronoun was used most frequently. In the indirect self-reference condition the "we" pronoun was substituted, while in the no self-reference condition the "it" pronoun was used.

Following the presentation of the transcripts all subjects were asked to complete three questionnaires: the Sorrenson Relationship Questionnaire (Sorrenson, 1967), the Counselor Rating Form (CRF) (Barak & LaCrosse, 1975), and the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962). The Sorrenson Relationship Questionnaire contains twenty four Likert scale questions by which subjects rate a counselor's degree of empathy and expertness. The

CRF assesses a counselor's expertise, attractiveness and trustworthiness by having subjects respond to thirty six related bipolar items. On every measure in the indirect self-reference condition, the "therapist" was rated as more empathic, competent and trustworthy. The direct self-reference "therapist" earned the lowest rating on these variables. Statistical significance, however, was seen only for differences between disclosure conditions on the competence and trustworthiness and not the empathy variables.

These results point to a possible optimum level of therapist disclosure in terms of degree of self-reference. Research in actual therapy situations could test this hypothesis.

Anderson and Anderson (1985) conducted an experiment to examine client reactions to the content of material disclosed by "therapists." More specifically, they examined differing reactions to therapist "positive and negative self-involving statements." This research was also analogous in that college students were substituted for actual clients who, rather than having face to face interactions with therapists, read transcripts of simulated therapy sessions. In this between groups design experiment, eighty two subjects listened to transcripts which were identical except for a few statements that either contained a positive or negative self-involving statement (for example, "I'm glad to see that you've made it," or, " I can feel your emptiness and that disturbs me").

All subjects then completed the Counselor Rating Form to rate the "therapists" in these transcripts. This measure was used to obtain subjects' rating of counselors' attractiveness, expertness and

trustworthiness. In addition, the subjects were asked to comment on two addition dimensions: the appropriateness of counselors' behavior and their own willingness to see this type of counselor.

In their analysis of the results, the authors found that subjects rated the positive self-involving "therapists" as significantly more appropriate, attractive and trustworthy, and they indicated that they would be more willing to see a similar type of counselor. The authors pointed out that the robustness of these results was demonstrated when the significances found held up under statistical correction for the multiple ANOVAs. The only sex difference apparent was that the male subjects' preferences to see positive self-involving therapists was even stronger that that of the female subjects.

These results may be difficult to interpret, given the lack of actual contact with a therapist. As with the Fox, Strum, and Walters (1984) study, subjects were rating such things as the personal attractiveness of an individual based solely on transcripts of communications. In addition, these subjects were not themselves patients who might have a different reaction to therapist disclosures. Future studies are needed to replicate these findings under less artificial conditions.

In a large study, Carter and Motta (1988) asked 300 college students to rate "therapists" who displayed varying levels of self-disclosure and formality. The therapists' communications were presented in a manner different from most studies in that subjects viewed one five minute video tape of a simulated therapy session. Six conditions were created in this between groups design experiment, based on three levels of self-disclosure (no, low, high) and two levels

of formality (low, high). The nature of the therapist's disclosure in this study was "negative" in that it referred to the therapist's own experience of depression. Independent raters who were blind to the nature of the study had previously rated these tapes to control for unintentional variations in the tapes.

All subjects then completed two questionnaires regarding the "therapist" they had just seen: the CRF and the Sorrenson Relationship Questionnaire. A significant difference was noted between the no-disclosure and high-disclosure conditions, with ratings higher for the no-disclosure condition. In terms of formality ratings, the therapist's trustworthiness was significantly higher in the informal condition. Significant interactions were seen between formality and disclosure. Ratings of expertness and empathy were highest in the formal, low intimacy situation and lowest in the informal, low intimacy situation.

When controlling for the formality component of this study, the experimenters found a direct relationship between the degree of "therapist" disclosure of personal depression and the subjects' ratings of the therapists' level of empathy, trustworthiness and expertness. High disclosures of depression led to overall lower ratings. The low ratings on empathy were less extreme when therapist disclosure was somewhat lessened.

This study suggests that the valence of what is disclosed by a therapist may have a direct effect on a patient's perception of that therapist. At the same time, two obvious limitations of the Carter and Motta (1988) study demand caution. First, as the authors remarked,

these impressions were only of a five minute segment and may therefore only be related to initial impressions which may alter with increased work with a therapist. The other limitation is characteristic of all research in this area in that the "therapy" situation was simulated and the "patients" were in fact college students. Further research is needed in actual therapy situations to determine the generalizability of these results.

Most recent in the research on reactions to therapist self-disclosure is the experiment by Lundeen and Schuldt (1989). In a manner similar to the Carter and Motta (1988) experiment mentioned above, Lundeen and Schuldt asked 160 college students to view a tape of a simulated therapy situation. In this experiment the tapes were ten minutes long and varied along two dimensions: "Therapist" self-disclosure (disclosure or non-disclosure) and a physical barrier (presence or absence of a desk between the therapist and the client). The content of the self-disclosure was not specified in the study.

After viewing the tapes, subjects completed the CRF. When the barrier effect was controlled for, no significant relationship was seen between therapist self-disclosure and expertness. Significant relationships, however, were found to exist between therapist self-disclosure, trustworthiness and attractiveness. That is, the self-disclosing "therapist" was rated higher on both of these variables.

In summary, the results of these studies showed strong overall support for the hypothesis that "therapist" self-disclosure is well received by subjects, and that in general subjects rate such

"therapists" highly on measures of expertness, empathy, trustworthiness and attractiveness. Subjects also expressed greater willingness to meet with a therapist who was self-disclosing. At the same time, these results suggest that the content of what is disclosed also affects subjects' perceptions, and that disclosure of "negative" information by "therapists" may have opposite results from those summarized above. These results are found in summarized form in Table 2. Many questions as to the effect of therapist's self-disclosure, however, are not addressed by this body of research.

Table 2

Valence of Subjects' Ratings of Simulated Self-Disclosing Therapists

	Therapist Qualities			
Investigators	Competence	Trustworthiness	Attractiveness	Empathy
Fox, Strum and Walters (1984)[a]	+ **		+ ****	+ ****
Loeb and Curtis (1984)				
Direct	- *	- *		- *
Indirect	+ *	+ *		+ ns
Anderson and Anderson (1985)[a]	+ ***	+ ***	+ ****	
Carter and Motta (1988)				
Negative	- ****		- ****	- ***
Lundeen and Schuldt (1989)		+ ****	+ ****	

[a] = Subjects expressed more willingness to see a "disclosing" therapist.
*p<.05. **p<.01. ***p<.005. ****p<.001.

Weiner (1983), pointed out two primary weaknesses that exist with analog studies. First, it is impossible know if an actual patient

would react differently to therapist self-disclosure than did research subjects. Second, it is not known whether the positive reaction to therapist self-disclosure would continue beyond an initial impression as therapy continues. Analog studies also do not question the possibly different effects of spontaneous versus planned disclosures. Finally, all research in this area, not only that of an analog nature, is limited by a lack of well defined measures which address the many components of self-disclosure, e.g., content, depth, breadth, timing, predictive validity, and the like.

Therapist Surveys

In addition to the experimental studies on patient's reactions to therapist's self-disclosure, a number of surveys and case studies have addressed this issue from the perspective of therapists themselves.

Matthews (1988) surveyed and interviewed 342 therapists about their beliefs concerning therapist self-disclosure. The therapists in the survey included psychiatrists, licensed social workers, and psychologists in Colorado, who were educated at the masters and doctoral levels. The surveys and interviews included directed questions about the therapists' views on and use of self-disclosure in psychotherapy. Included were questions about the varying use of self-disclosure with clients having different diagnoses.

Matthews (1988) did not report any systematic differences related to the therapists' discipline or level of education. What she did report were a number of common justifications by respondents both in favor and against using deliberate self-disclosure. Those in favor of self-disclosure stated that it was useful (a) in promoting feelings of

universality, and (b) in providing reality testing. The commonly cited reasons to avoid self-disclosure were (a) the removal of a patient focus, and (b) the disruption of the transference. Matthews stated that there was much disagreement about the issue of transference. Descriptive statistics were not provided, however, making it difficult to understand the magnitude of this split. Finally, in terms of the diagnostic issue, Matthews reported that therapists all agreed that the diagnosis of their clients affected their views about self-disclosing. In particular, with respect to clients with a narcissistic personality diagnosis, all of the therapists indicated that self-disclosure to such a patient was at the least not of interest and at most destructive to treatment.

Simon (1988) conducted interviews with eight experienced therapists from the disciplines of clinical social work, psychiatry and psychology, regarding their attitudes toward the practice of intentional self-disclosure with their clients. Simon selected therapists for his interviews who expressed extreme views concerning the advisability of therapists' self-disclosure. In addition, these eight experienced therapists all had at least ten years of experience in private clinical work. Simon pursued three lines of questioning in these interviews: (a) the psychotherapy relationship, (b) the therapist's theoretical orientation, and (c) the therapist's self-awareness.

Simon did not present any actual results from these interviews, but instead described what she considered to be critical in these eight therapists' responses. All eight therapists' admitted to self-

disclosing at times in their work with clients. According to Simon, the main factor affecting the difference in perspective of these therapists as to their opinion of the advisability of self-disclosure was their theoretical orientation. Simon added, however, that theoretical orientation in itself was an incomplete explanation for the differences, and that factors such as the psychotherapeutic frame, the psychotherapeutic relationship, the therapist's personality, and the therapist's self-awareness also influenced their positions regarding self-disclosure.

Unfortunately, it is difficult to determine to what extent Simon (1988) was reporting the viewpoints of the therapists she interviewed, and to what extent she was expressing her own viewpoint. The author's bias toward less self-disclosure with patients is apparent in this paper, and appears to have influenced the way in which she described such topics as the self-awareness of the therapists she interviewed. Finally, the decision to use therapists who were extreme in their viewpoints on self-disclosure was not justified by the author, but it may have created a biased perspective as to how most therapists feel about self-disclosure.

Anderson and Anderson (1989) surveyed 96 therapists to inquire about their use of self-disclosure in psychotherapy. Their population sample included a range of credentialed (bachelor's to doctoral degree) and experienced (one to ten or more years experience) therapists. The sample also contained a similar number of males and females. Sixty-seven subjects were from college counseling centers, and 29 worked in an inpatient, private practice or other setting. In

terms of orientation, 33 were identified as either cognitive-behavioral or humanistic, 6 as psychodynamic, and 24 as some combination of these three orientations.

Subjects were asked to rate themselves in terms of the frequency of their disclosures of eleven types of information: demographic, personal identity, professional experiences, world view, opinions/attitudes, metaphors/images, emotional responses (positive and negative) and personal experiences (personal strengths and past and present weaknesses). When these variables were factor analyzed, three factors emerged which the researchers labeled "personal involvement or personal disclosure," "affective disclosure," and "professional disclosure."

The authors suggested that these factors be conceptualized in terms of client vs. therapist focus and level of personal involvement of the therapist. In this regard, "personal disclosure" would signify high personal involvement and therapist focus. "Affective disclosure" would correspond with high personal involvement as well, but with a client focus. Finally, "professional disclosure" would relate to a low level of personal involvement with a therapist focus.

The authors also conducted analyses of variance for demographic variables, which revealed no significant differences according to sex, level of education and therapeutic orientation. Experience level, however, was significantly correlated with overall disclosure. Pairwise comparisons of the levels of this variable revealed only that those counselors with one year or less of experience disclosed significantly less than those with ten or more years of experience.

Disclosure did not significantly vary between other levels of experience.

Disclosure rates across work settings were also significantly different, when college settings were compared to all other settings combined. Subjects from college counseling centers reported less disclosure. However, this result may be an artifact of the typical lack of experience of the subjects in this study who were working in college settings. The Anderson and Anderson (1989) survey provided a conceptualization of dimensions of therapist self-disclosure that help to guide research in actual therapy situations.

In summary, it is clear from the results of these surveys that therapists do not agree about the impact that therapist self-disclosure has on clients in psychotherapy. The magnitude of this variance is unfortunately difficult to assess given the lack of data that is presented in the reports of these surveys. Nevertheless, differences most certainly do exist. The range of opinions on this subject seem to be at least partially related to the various ways in which therapists conceptualize the psychotherapy relationship. However, this explanation is likely incomplete.

It is argued further on in the present paper that these differing opinions parallel a tension that always exists in a therapeutic relationship. Before this issue is addressed, though, some case examples of therapists' self-disclosure will now be reviewed.

Case Studies

Few examples exist of therapists' actual self-disclosures. This is due possibly to the vulnerability of writing about such experiences

with clients. Fortunately, there are exceptions to the lack of case studies. Olarte (1985) presented two case histories of her own work as a psychotherapist, which illustrate the use of deliberate therapist self-disclosure with a client. Her discussion of having self-disclosed with two clients emphasized the choice of when and in what manner to share personal information. In the first case, Olarte described having chosen to disclose her own experience of developing a professional role, in order to provide a model to her client who was then facing a similar developmental step. Olarte described this modeling as having assisted in the process of the patient's experiencing of an "integrating synthesis" of her feelings (p. 262).

In the second case, Olarte (1985) shared with a client her own experience of struggling to be both a parent and a professional. Her purpose was to assist the patient in his "integrating his beliefs in equality for both sexes with his psychodynamics" (p. 264). In both of these cases, Olarte described such deliberate self-disclosure as serving a teaching function, similar to that of a mentor, where knowledge is imparted. She indicated that the timing of this disclosure in the course of the psychoanalytic treatment occurred when the the patient's uncovering process of obtaining insight into his own unconscious was largely complete. According to Olarte, the purpose of this disclosure was to facilitate a change in stereotypic behavior "at the stage in therapy when the patient has already understood his/her psychological patterns, and is highly identified with the person of the therapist, who through his or her analytic

work has shown dedication, appreciation, empathy and care" (p. 266).

Simon (1987) has also described a case in which she, as a psychopharmacologist, chose to self-disclose with a female patient. Simon first stated that she does not typically self-disclose in her work with her patients, and that she views self-disclosure as a frequently used means of avoiding a therapeutic task. In this case, however, her self-disclosure was spontaneous in nature, and was said to have the positive effect of reducing her patient's sense of alienation. As with the cases presented by Olarte (1985), Simon viewed the function of her self-disclosure as providing that of a role model to her patient, not so much within the context of a doctor-patient relationship as a relationship between two women.

In summary, these case examples of therapists' self-disclosure provide examples of how such interventions can contribute to positive therapeutic change. The frankness of such case studies is a much needed example of how self-disclosure impacts actual therapy situations. The following section discusses and attempts to integrate the findings from the research on therapist self-disclosure with a theoretical understanding of the therapeutic relationship. Also discussed is the differing perspectives of clients and therapists, and between therapists themselves.

The Therapeutic Relationship

In order to understand the meaning of therapist self-disclosure in the context of the therapeutic relationship, it is important to have a

comprehensive framework to conceptualize the nature of therapeutic change. The present study examines three key aspects of the therapeutic relationship, including the working alliance, the transference relationship and the real relationship. This examination of the fundamental workings of the therapeutic relationship avoids theoretical differences which potentially might blur a direct understanding of the impact of therapist self-disclosure. Furthermore, while the content of therapist self-disclosure is also an important issue, the content of therapist self-disclosure will be set aside in order to highlight the process of a self-disclosing stance.

Gelso and Carter (1985) have thoroughly summarized the major writings regarding the psychotherapy relationship. In their extended paper, they proposed three primary components to this relationship: (a) the therapeutic alliance, (b) the transference or unreal relationship, and (c) the real relationship. Although in an actual therapeutic relationship it is often difficult to distinguish these components from each other, this paper provides a clear, highly defined perspective on the impact of therapist self-disclosure in psychotherapy.

The lack of unilateral agreement among therapists as to the appropriateness of any form of self-disclosure to their clients has been noted earlier in this paper. Palombo (1987) argued that therapists fall into one of three camps in terms of their views on therapist self-disclosure: (a) those who consider it acceptable, (b) those who view it as necessary but undesirable, and (c) those who

view it as not therapeutic. These views are examined separately in light of the three aspects of the therapeutic relationship.

The Working Alliance

Gelso and Carter (1985) defined the working alliance as that aspect of the therapeutic relationship which develops first, and "is the alignment that occurs between counselor and client or, more precisely, between the reasonable side of the client (the observing or reasonable ego, in analytic terms) and the counselor's working or therapizing side" (p.162). Therapists are said to bring to this alliance both professional concern and compassion, and a willingness to help clients work through their difficulties. Central to this stance, as suggested by Gelso and Carter, are the conditions of empathy, genuineness, and respect.

Weiner (1983) described how therapist self-disclosure can be of benefit to the working alliance. This includes "heightening the patient's self-esteem by conveying respect and facilitating identification with a respected person (the therapist)," and "gratifying a patient's transference and object needs to establish and maintain a therapeutic alliance" (p. 111). At the same time Weiner pointed out that it is unethical for a therapist to self-disclose in order to entice an unmotivated client into therapy. For example, by self-disclosing a therapist may erroneously imply that the therapy relationship will be one of mutual and equal openness. This is a misrepresentation of the nature of the therapy relationship.

Therapist self-disclosure may actually interfere with the forming of a therapeutic alliance. A client might become intimidated if a therapist shared of his or her personal experiences or opinions, and might flee therapy out of fear that the therapist would judge him or her. Curtis (1982) has emphasized that self-disclosure can interfere with "therapeutic bonding" (p. 908) and has even devised techniques of therapist non-disclosure when clients specifically request that therapists self-disclose. These include clarifying why a client has requested personal information, and using impersonal analogies to improve the appropriateness of client inquires.

The Transference Relationship

The second component of the therapeutic relationship is the transference relationship, or what Gelso and Carter (1985) called the "unreal relationship" (p. 169). The authors defined this component of the therapeutic relationship as that in which "past conflicts (usually but not always beginning in early childhood) with significant others . . . are displaced . . . onto the therapist. . . . Transference entails a misperception or misinterpretation of the therapist, whether positive or negative" (p. 170). In their discussion of the role of transference in psychotherapy, Gelso and Carter pointed out that the phenomenon is ubiquitous, and therefore must always be addressed at some level. The extent to which the transference is fostered, cultivated, addressed and dealt with directly, or ignored varies greatly across therapeutic modalities.

Those therapists who address the issue of transference in psychotherapy often see it as the vehicle by which patients'

unconscious and unresolved conflicts are discovered and worked through. This traditional position taken in psychoanalytic psychotherapy is that in order for the transference to develop maximally, the therapist must take a neutral position, what Freud (1912) described as a mirror image role. In doing so, the therapist presents himself or herself to the client as a blank canvas (mirror) onto which the client will project unresolved conflicts with people in his or her past. To not take a neutral position would be to risk "contamination of the transference" (Curtis, 1981).

The corresponding component to the patient's transference in the therapeutic relationship is that of the therapist's countertransference, which is simply defined as the therapist's own transference to the communications of the client. Palombo (1987) conceptualized countertransference as occurring at three levels: (a) the concordant, (b) the complementary, and (c) the disjunctive. He addressed the issue of therapist disclosure at each of these levels.

At the concordant level, the therapist's reactions are seen as generated by an attempt to remain in empathic contact with his or her client. Two types of self-disclosure are said to occur at this level. The first is public information which the client might otherwise obtain. Typically, in order to maintain a therapeutic alliance, a therapist may disclose this information to a client to avoid a possibly embarrassing situation at a later time. For example, a therapist might not initially acknowledge having a social relationship with one of the client's peers. If, however, the client began discussing his or her ambivalent feelings toward that peer and later learned of the

therapist's relationship with that person, the client might then feel betrayed by the therapist. The therapist would likely find it difficult to respond when confronted with his or her "deception." Generally, self-disclosure of public information avoids such potential dangers. The other type of disclosure at this level occurs when a therapist's past experience is similar to that which a patient is describing, and is evoked and shared either spontaneously or intentionally. Palombo (1987) argued that the outcome of such disclosure is highly unpredictable with possibly adverse effects. The manner in which the therapist resolved his or her own situation may not be possible for the client, thereby increasing the client's frustration. Alternately, the sharing of what the therapist views as a similar experience may not be seen as similar by the client. The client might then feel misunderstood. Finally, self-disclosure of similar experiences might too quickly offer a solution to a client, thereby circumventing the client's need to personally resolve a conflict.

A second level of countertransference is the complementary response. Here the therapist, participating in the regressive experience of the client, comes to feel either in the same way the client's actual parents felt toward the client, or as the client may have wished his or her parents to respond. The therapist's self-disclosure in this context would be the result of this experiencing himself or herself as the patient's parent. There is here the potential for both re-traumatizing the patient, or providing the possibility of a corrective emotional experience.

Finally, Palombo (1987) described a third level of countertransference which he calls the disjunctive response. This level of countertransference is said to stem from the therapist's own psychopathology, insensitivity or technical ineptness. Self-disclosures of such disjunctive responses are always viewed as negative.

Weiner (1983) suggested that one way in which therapist self-disclosure can be useful in the transference relationship is as a tool in resolving transference resistances. This may occur when a therapist clarifies his or her actual thoughts and feelings, thereby correcting a client's distorted perceptions. For example, when a patient who is psychotic believes the therapist wishes the patient harm, a direct confrontation of this perception might prevent further distortion. By and large, however, the use of therapist self-disclosure has been viewed as negatively impacting the transference relationship.

Weiner (1983) identified some of the misuses of therapist self-disclosure, which may be related to the therapist's countertransference reactions. They include disclosing in order to: (a) manipulate a patient's feelings, (b) meet the therapist's social, sexual or psychological needs, (c) provide an outlet for the therapist's feelings, (d) help the therapist defend him or herself against personal feelings, (e) enable a therapist to avoid facing feelings of incompetence or indifference to a client, (f) reinforce a patient's avoidance or pathological defenses, (g) increase a patient's need for intervention or gratification by therapist, (g) obstruct the termination process, (h) force a patient to act in a self-detrimental manner, (i)

lead to an identification with the unhealthy aspects of the therapist, and (j) repeat earlier trauma (p. 130).

Finally, Horner (1987) also emphasized the danger of self-disclosure being affected by the transference relationship. She wrote that patients

> often suffered from the consequences of having had their parents react transferentially to their realness, with negative labels being assigned to their basic nature. . . . We have to be careful no to do with interpretation what parents did with labeling--not to pathologize the patient's healthy and intrinsic nature--but to distinguish it from his pathology and to affirm its fundamental value. (p. 492)

Horner believes that realness is important on the part of therapists, but that therapists must always monitor themselves to avoid acting out their own conflicts and needs with their clients.

The Real Relationship

The final component of the therapeutic relationship is the nontransference or real relationship. Writers disagree on the extent of the role that the real relationship plays in the therapeutic relationship. Gelso and Carter (1985) defined this component as that which "consists of the participants' genuine and realistic perceptions of and reactions to each other." (p. 185). These authors suggested that realism is important in order to avoid contamination of therapist communications by countertransference. In this context, Gelso and Carter defined the therapist's contribution to the real relationship as achieved "through his or her genuineness, facilitation of the client's genuineness, and the abiding attempt to see and understand the client realistically" (p. 187).

A point of contention among writers is whether the perceptions and reactions in the real relationship must be completely realistic. Greenberg (1985), in response to Gelso and Carter (1985), argued that what is crucial to the real relationship is not whether it is realistic or not, but that it is "two human beings in the counseling situation stubbornly attempting to dispense with appearances and genuinely [revealing] themselves as they truly are in the moment" (p. 254). They suggested that honesty sometimes has a value independent of accuracy. In this regard, Greenberg emphasized the importance of a "reciprocal role relationship" which provides maximum freedom for therapists and clients to express their true feelings (p. 255).

Horner (1987) helped to clarify this issue, attempting to define the term "real" in the real relationship. She stated that "it may mean 'realistic', reality oriented or undistorted as contrasted to the term 'transference' which connotes unrealistic, distorted and inappropriate. The word may also refer to genuine, authentic and true in contrast to artificial, synthetic or assumed" (p. 491). Horner suggested as well that it is possible to see the three components of the therapeutic relationship in terms of their relationship to the degree of its realism and genuineness. The therapeutic or working alliance may be realistic while at the same time it may not be genuine. The transference relationship is genuine but may not be realistic. Finally, the real relationship is both genuine and realistic.

Horner (1987) argued further that the merging of the genuine and the realistic is crucial to the relational health of a client. She stated that

> perhaps it is the genuineness of empathic mirroring that is most significant, inasmuch as it reinforces the patient's sense of genuineness. However, at some point, what is genuine must join with what is realistic if there is to be a capacity for a real relationship in or out of therapy. (p. 492)

Weiner (1983) has specifically described some of the ways in which therapist self-disclosure can be of benefit to the real relationship. They include: (a) enhancing the patient's reality testing by defining the therapist as a real person and by defining the real patient-therapist relationship, (b) providing feedback about the impact of the patient on others, (c) providing a corrective emotional experience, (d) promoting identification with the positive aspects of the therapist, (e) humanizing a relationship with a dehumanized, chronically ill patient, (f) helping a patient discover his or her emotional assets, and (g) explaining an important change in the therapeutic relationship (p. 111).

In summary, what must be emphasized is the tension between the need for realism and genuineness on the part of the therapist, as well as the danger of responding to a client on the basis of countertransference. It is at this juncture that therapists differ in their opinions as to the advisability of a therapist's self-disclosure. Therapists on both sides of this debate, including those who rarely self-disclose and those who do so regularly, often address but one side of this tension. On the one hand, the transference relationship must be acknowledged and along with it the dangers associated with

misguided therapist self-disclosure. On the other hand, the needs of clients for relatedness requires some openness and honesty on the part of their therapists.

Robbins (1988) elaborated on such client needs. He described what he referred to as the schizoid characteristics which are common to some extent in all patients, and the need clients have for a real relationship with their therapists. Robbins argued that common to all clients are emotional states of isolation and emptiness, and that, "pockets of this aloneness and dissociation can be found in all of us regardless of the specific character armor we wear or the unique family history we carry with us" (p. 395). Robbins inferred that these states impede real interpersonal contact and that when they occur in therapy they prevent the development of positive transference. He sees the function of the therapist's real communications as developing a transitional space which "bypasses the patient's character defenses and resonates with the patient [and] becomes a conduit for the development and processing of transference material" (p. 397).

Concluding Comments

This paper has surveyed the research on therapist self-disclosure, from the viewpoint of both client and therapist. While in most cases clients (and experimental subjects in an analog role) show a strong preference for self-disclosing therapists, therapists themselves express much more ambivalence and disagreement over the value and appropriateness of self-disclosure. The difference between

clients' and therapists' opinions can be explained partially in terms of therapists' greater understanding of the transference phenomenon, and their deeper recognition of the tension between the needs to be both neutral and real with clients. The varying degrees of emphasis that therapists place on the transference relationship parallels the disagreements among therapists of differing orientations over their beliefs about the place of therapist self-disclosure in psychotherapy. The more the transference relationship is emphasized, the less self-disclosure is valued. The opposite is also true.

Despite the possibility that clients have a simplistic view of the psychotherapy relationship, their overall positive response to therapists' self-disclosure cannot be ignored. Perhaps clients' opinions can serve as a corrective to therapists who, through too exclusive a focus on the transference relationship, ignore the fact that despite the special nature of the psychotherapy relationship, it nonetheless remains a real relationship. To treat it otherwise is to distort reality.

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